PUBLIC HEALTH NURSING

Indian Health Service

Preventive Health	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Public Health Nursing					
Budget Authority	$34,452,000	$36,114,000	$37,781,000	+$3,329,000	+$1,667,000
FTE	287	289	294	+7	+5
Total # of Pt. Visit	340,000	370,048	376,048	+36,048,000	+6,000
Total # of PHN Home Visits Provided	119,000	126,373	128,000	+9,000	+1,627

PURPOSE AND METHOD OF OPERATION

Program Mission/Responsibilities

The IHS Public Health Nursing (PHN) is the integration of nursing practice and public health practice applied to the prevention of disease and the promotion and preservation of the health of the Indian population. PHN services are provided to individuals, families, groups, and through these services contribute to the health of the community.

The majority of AI/AN live in rural and isolated communities. Access to modern convenience such as telephone and transportation are not necessarily available to access medical care. Often the PHN is the link to health care in these remote communities. Access to medical care is also a challenge for some AI/AN members who live in urban settings.

PHN is one of the most visible and well-known programs to the Indian tribes because it is entirely community based. Their services are based on the assessed needs of the individuals, families, groups, and communities. The PHN role is one of health education, strengthening relationships with the Indian community and providing the framework for broadly based community efforts, which include: therapy, counseling, education, and coordination of care by referring clients to other disciplines and case management activities. The PHN collaborate with the health care team to deliver the required services.

Best Practices/Industry Benchmark

The PHN program is an integral component in the Indian Health Service/Tribal/Urban (ITU) health programs. The tribes operate approximately one third of the PHN programs. Outreach activities include: home visits, well child examination in remote communities, immunizations, prenatal care and follow up visits for skilled and non skilled nursing care. Home visits continue to be a mainstay of the PHN activities along with case finding which together accounts for over 50 percent of the PHN

time. Another 20 percent of the PHNs time is spent in activities for children under the age of 5 years. This is a collaborative effort with the Maternal and Child Health (MCH) team.

Because the PHNs are community based their coordination of care includes STDs, AIDs counseling, and education on FAS/FAE. Community assessment and developing population based plans of care are another important PHN activity. Collaboration with State and county agencies to plan appropriate programs to meet the needs of the Indian community often requires input from the I/T/U PHNs.

Findings Influencing FY 2002 Request

PHN services related to preventive care are directly influenced by PHN home visits, including Prenatal care, high immunization rates, post hospitalization home visits for skilled and unskilled nursing care.

The IHS service population is increasing at a rate of about 2 percent per year. The health needs of the growing elder population are increasing at 15 percent of the PHNs home visits. There is increasing priority to address the health disparities that are identified for the AI/NA population.

Public Health Nursing continues to work to eliminate health disparities. American Indians/Alaska Natives have higher rates of cervical cancer. PHNs make home visits to educate at risk women and encourage early screening and follow up to missing appointments.

AI/AN have higher incidence and prevalence of diabetes mellitus and its complications. PHNs conduct home visits to educate the importance of glycemic control to delay the onset of complications based on a plan of care. Hypertension and heart disease are often co-existing conditions with diabetes forcing resources to be channeled into tertiary interventions.

PHNs collaborate with other members of the Maternal and Child Care team to improve health outcome for the mother and child. AI/AN is a young population, greater than 50 percent of its population is in the childbearing years. PHNs make home visits to increase first prenatal visits in the first trimester. Home visits are made to those prenatal patients who have risk factors such as smoking, alcohol and drug use in pregnancy which correlate with poor outcome for the baby. There is documentation that mothers and their children who receive PHN home visits have better outcomes. In F.Y. 2000, 39 percent of the PHNs services were to maternal, child health promotion.

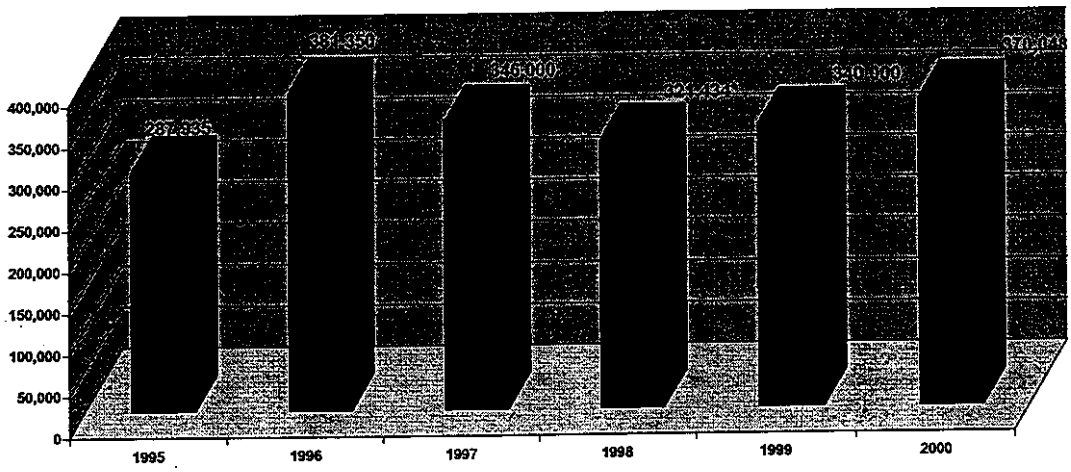
Pockets of AI/AN continue to experience incidences of infectious disease, such as Tuberculosis and Hantavirus, which require stringent investigation of the environment and education on prevention.

Some of the PHN programs have successfully passed accreditation by the National League for Nursing, while many programs have chosen not to continue this accreditation process due to varying funding priorities. In FY 2002, IHS will continue to work with PHN programs on accreditation so that the PHN programs could continue to meet national standards.

ACCOMPLISHMENTS

The PHN program has been challenged by vacancies that have not been filled but the PHN program has seen gradual increases in services and a positive clinical outcome of decrease infant mortality rates (see attachment A & B). Also despite these shortages, the PHN program funded four PHN interns, Alpha and Beta tested the PHN PCC form that will generate more specific data, and provided PHN Update Training for Indian countrywide.

PHN Service Data FY's 1995 thru 2000



PERFORMANCE PLAN

The following performance indicators are included in the IHS FY 2002 Annual Performance. These indicators are sentinel indicators representative of some of the more significant health problems affecting AI/AN. At the FY 2002 funding level, IHS would be able to accomplish the following:

Indicator 2: During FY 2002, continue the trend of improved glycemic control in the proportion of I/T/U clients with diagnosed diabetes.

Indicator 3: During FY 2002, continue the trend of improved blood pressure control in the proportion of I/T/U clients with diagnosed diabetes who have achieved blood pressure control standards.

Indicator 8: During FY 2002, increase the proportion of AI/AN children served by IHS receiving a minimum of four well-child visits by 27 months of age by 2 percent over the FY 2001 level.

Indicator 22: During FY 2002, increase by 2 percent the total number of public health nursing services (primary and secondary treatment and preventive services) provided to individuals in all settings and the total number of home visits over the FY 2001 workload levels.

Indicator 23: During FY 2002, increase the proportion of AI/AN children who have completed all recommended immunizations for ages 0-27 months (as recommended by Advisory Committee on Immunization Practices) by 1 percent over the FY 2001 level.

Indicator 24: During FY 2002, increase pneumococcal and influenza vaccination levels among adult diabetics and adults aged 65 years and older by 1 percent over the FY 2000 level.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE	
1997	$26,676,000	289	
1998	$28,198,000	289	
1999	$30,363,000	284	
2000	$34,452,000	287	
2001	$36,114,000	289	Enacted

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $37,781,000 and 294 FTE is an increase of $1,667,000 and 5 FTE over the FY 2001 enacted level of $36,114,000 and 289 FTE. The increases include the following:

Built-in Increases: +$1,244,000

The request of $240,000 for inflation/tribal pay cost and $1,004,000 for federal personnel related costs would fund the built-in increases associated with on-going operations. Included is the FY 2002 pay raise and within grade increases. These funds will be shared with Title I and Title III tribes, as well as Federal programs.

Maintaining the current I/T/U health system by ensuring access and continuity of care is necessary in eliminating disparities in health status between AI/ANs and the rest of the U.S. population.

Phasing-In of Staff for New Facilities: +$423,000 and 5 FTE

The request of $423,000 and 5 FTE provides for the phasing-in of staff and related costs for new facilities. The staffing of new facilities also contributes to the recruitment and retention of medical staff and promotes self-determination activities. The following table displays the requested increase.

Facilities:	**Dollars**	**FTE**
Parker, AZ Health Center	$423,000	5